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Issue Brief on Health Care for the Uninsured

How many people lack health insurance in LA?

In 1999, 22.5% of Louisianians (984,000 people) were without health insurance throughout the year, up from 19% (829,000 people) in 1998. LA had a greater proportion of its population without health insurance coverage than either the U.S. (15.5%) or the South (17.6%). The state ranked 3rd highest in the nation in the percentage of its population that was uninsured. Only New Mexico (25.8%) and Texas (23.3%) ranked higher.

Why are so many uninsured?

Several factors contribute to the growing numbers of uninsured in LA, including rising health insurance premium costs, decreasing employer contributions to health insurance premiums, decreasing employer-sponsored health insurance coverage, large numbers of small businesses, large numbers of low-income people, and gaps in the state Medicaid program.

Who are the uninsured?

The uninsured are almost entirely *non-elderly*, since 99% of those over 65 are covered by Medicare.

Most are *adults*. Between 1996 and 1998, 69% of LA's uninsured were between the ages of 19 and 64 (579,000 adults) and 31% were under 19 years (259,000 children).

Most are *low-income*. Between 1996 and 1998, 63% of uninsured Louisianians earned less than 200% of the Federal Poverty Line, or $27,300 for a family of 3 in 1998. Medicaid covered some of LA's low-income population (26.7%), but 34.5% remained uninsured during the same period.

Many are *workers*. In 1997, 1 in 5 LA workers were uninsured. Nearly 4 in 5 uninsured workers did not have access to employer-sponsored health insurance coverage. More than half of uninsured workers were employed in *small firms* (less than 100 employees). Workers in small firms were twice as likely to be uninsured as those in large firms.

What difference does health insurance make?

Research has shown that the uninsured are less likely to get preventative and primary care, less likely to have continuity of care, more likely to be diagnosed and treated at a later stage of illness, more likely to be hospitalized for avoidable conditions, and have higher death rates.

Where do the uninsured get care in LA?

State hospitals provide the bulk of indigent care in LA. LSU hospitals provide inpatient and outpatient medical care, and DHH psychiatric hospitals provide inpatient and outpatient care for the mentally ill. Non-state hospitals and private practice physicians also provide inpatient and outpatient medical care. Federally Qualified Health Centers (FQHCs) provide preventative and primary medical care.

Who pays for health care for the uninsured?

The primary means of finance for indigent care in LA is the Disproportionate Share (DSH) program. DSH pays for uncompensated care provided by hospitals that serve a disproportionate share of the state's low-income and uninsured population.

Not every hospital receives DSH. Federal rules require hospitals to care for a minimum amount of Medicaid or uninsured patients in order to be eligible for DSH. States may, however, lower the federal minimum requirements, as LA has done for small and rural hospitals. About half of all LA hospitals are paid DSH. Roughly one quarter of DSH hospitals are state hospitals and the other three-quarters are mostly small, rural non-state (public and private) hospitals.

Funding for DSH comes from state and federal sources. Overall, 70% of DSH comes from the federal government and 30% from the state. The vast majority of the state matching funds come from the State General Fund. Unlike other states, LA has not used local funds via Intergovernmental Transfers, provider fees or tax assessments on hospitals for state match for DSH.

In FY 1999-2000, the state paid a total of $821 million in DSH ($579 million federal DSH funds and $242 million state match). $710 million or 86% of the state's DSH payments went to LSU hospitals ($596 million to the 9-hospital HCSD system and $114 million to Shreveport). $80 million or 10% of the total went to 4 DHH psychiatric hospitals. $29 million or 4% of the total went to 68 non-state hospitals.

The Louisiana Hospital Association estimates that non-state hospitals ineligible for DSH provided $120 million of uncompensated care for which they received no reimbursement.

With a total budget of $12 million in 1999, federally qualified health centers in the state cared for 80,000 people, roughly half of whom were uninsured. FQHCs depend on federal grants and cost-based reimbursement from Medicare and Medicaid to cover their indigent care costs.

Private practice physicians also provide "free" care to the uninsured. The value of this care is unknown.

Sources: U.S. Census Bureau, Current Population Survey, March 1998, 1999, and 2000; Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Chart Book*, March 2000; DHH; LA Primary Care Association; LA Hospital Association.

How do other states provide and pay for health care for the uninsured?

Generally, states take one of two approaches to indigent health care. Some primarily take a **provider safety net** approach. Others primarily take an **insurance safety net** approach. But most all states mix the two approaches.

Provider safety net states make direct payments to a limited number of hospitals that serve a disproportionate share of the poor and uninsured. Most such states favor public or private providers, rather than balancing indigent care between them.

Provider safety net states pay for indigent care primarily with DSH. DSH payments are a mix of federal and state funds. State funds generally comes from Intergovernmental Transfers or provider taxes or fees rather than the State General Fund.

LA primarily takes the provider safety net approach. Like many other provider safety net states, LA pays DSH to a few, mainly public hospitals. But unlike most such states, LA makes limited use of IGTs, assesses no hospital provider fees, and relies on SGF for most of the state match.

Insurance safety net states support health insurance expansions to cover the uninsured. Such expansions have used public and private sector insurance and been paid for by public and private funds.

Policy options commonly used by other states to expand health insurance coverage to the uninsured are the Children's Health Insurance Program, Medicaid 1115 waiver, Section 1931, and public subsidies for employer-sponsored health insurance for low-income workers.

State Children's Health Insurance Program (CHIP)

CHIP allows states to expand the income limit for Medicaid eligibility for children and parents, and provides a higher federal match than the basic Medicaid program. All 50 states have CHIP programs that cover kids, and some states have opted to cover parents, too. The income limit for CHIP eligibility varies by state. 17 states set the limit between 150% and 200% of the Federal Poverty Line. 10 states set it between 200% and 350% of FPL, with sliding scale premiums and co-pays for families who earn above 200% of FPL.

In LA, Medicaid eligibility is limited to kids under 7 with family incomes of up to 133% of FPL, kids ages 7 to 18 with family incomes up to 100% of FPL, and parents of minor children up to 22% of FPL. LaCHIP extends the Medicaid eligibility limit for all kids to 200% of FPL, but not to parents at any income level. Nationally CHIP parents account for roughly half of all low-income uninsured adults.

1115 Waiver

1115 waivers waive certain requirements of the Medicaid program for "research and demonstration" purposes for a 5-year period. 9 states have 1115 waivers. Each state's waiver program is different, but in general 1115 waivers are used to expand Medicaid eligibility to new groups without increasing Medicaid costs to the federal government.

1115 states typically expand Medicaid coverage to low-income kids, parents and/or childless adults by waiving the requirement that a person be disabled or poor *and* a senior, child, pregnant, or single parent to qualify. They avoid increasing federal Medicaid costs by waiving the requirement that Medicaid participants have freedom of choice of health care providers and enrolling them into managed care organizations.

LA applied in 1995 for an 1115 waiver to create a state hospital-based managed care organization for all uninsured. The federal government (HCFA) rejected the application.

Section 1931

Prior to federal welfare reform in 1996, state eligibility rules for Aid to Families with Dependent Children (AFDC) and Medicaid were the same. Nationally, the old AFDC rules included income limits of 40% of FPL or less, asset limits of $1,000, and a 100-hour work history limit. These rules essentially restricted Medicaid coverage to very poor, unemployed or underemployed, single parents. The 1996 federal welfare reform law allowed states to develop separate Medicaid eligibility rules.

Several states have used Section 1931 to cover low-income, working, two-parent families by raising the income limits to at least 100% of FPL, raising the asset limit to $2,000 or more, and dropping the "100-hour rule." Unlike the 1115 waiver, 1931 changes do not require budget neutrality or federal approval; states may simply amend their state Medicaid plan.

Since 1996, LA has raised its asset limit but still uses the AFDC income limit of 16% of FPL for parents ($2,280 for a family of 3) and the 100-hour rule.

Public Subsidies for Employer-Sponsored Health Insurance for Low-Income Workers

Medicaid and CHIP funds may be used to provide health insurance coverage for low-income workers and their families.

States may leverage federal Medicaid funds to pay premiums, deductibles and co-pays for private, employer-sponsored health insurance coverage when it costs less than enrolling the individual or family in the state Medicaid program and when private benefits are as generous as the state's. 5 states use Medicaid funds for this purpose.

CHIP may also be used to pay for cost-effective, equally generous, employer-sponsored coverage for low-income families, but only if the employer contributes 60% of the premium. 3 states use CHIP funds to this end.

LA uses neither Medicaid nor CHIP funds to subsidize employer-sponsored health insurance coverage for low-income working families, in part because so few employers sponsor health insurance coverage and because initial estimates suggested private coverage was not cost effective.

Sources: RWJ State Coverage Initiatives, *State Approaches to Expanding Family Coverage*, May 2000; NCSL, *Expanding Health Coverage to Working Families: State Options*, June 2000; Institute of Medicine, *America's Health Care Safety Net*, 2000.

LOUISIANA'S CURRENT APPROACH INDIGENT HEALTH CARE

- ***LA takes primarily a provider safety net approach, and has only modestly expanded Medicaid eligibility beyond federal minimums.***

Provider Safety Net	Insurance Safety Net
• LA makes the vast majority of its Uncompensated Care (UCC) payments to public rather than private providers. • In FY 99-00, 96% of LA's total UCC payments went to state hospitals. • 86% of the total went to LSU hospitals. • 56% of the total went to the state's two major urban teaching hospitals (MCLNO & LSU Shreveport). • Only 4% went to 68 non-state hospitals. Most of these are small and rural, some of which are private but most are public. • Unlike most provider safety net states, LA depends on State General Fund for the state match rather than Intergovernmental Transfers or provider taxes or fees. • LA is also different from most other provider safety net states in that our primary Disproportionate Share hospitals are part of a state-run system of hospitals. Most states have autonomous, county or municipal hospitals. The most significant differences between a state system and autonomous local government hospitals are that 1) the cost of indigent care is a state rather than local government issue, and 2) indigent care is rarely coordinated among autonomous hospitals across a state.	**Medicaid eligibility limits for the non-elderly, non-disabled** • Children under 7 in a family with income up to 133% of poverty • Children ages 7 to 18 in a family with income up to 100% of poverty • Pregnant women with income up to 133% of poverty • Parents of minor children with incomes up to 22% of poverty • No (non-pregnant) childless adult is eligible at any income • Work limits of 100 hours for families limit eligibility to the un- and under-employed • No use of Medicaid to subsidize employer-sponsored health insurance coverage for low-income workers **LaCHIP eligibility limits** • Children up to 19 years in a family with income up to 200% of poverty • No parent is eligible at any income • No use of CHIP to subsidize employer-sponsored health insurance coverage for low-income workers

PROS AND CONS OF ALTERNATIVE APPROACHES TO INDIGENT CARE

Provider Safety Net			Insurance Safety Net		
Policy options	***Pro***	***Con***	***Policy Options***	***Pro***	***Con***
Increase Uncompensated Care (UCC) payments to non-state hospitals that provide a disproportionate share of indigent care E.g.: • Additional direct UCC payments to qualifying hospitals, such as with December BA-7 for large public and small rural hospitals • Additional indirect UCC payments to non-state hospitals via LSU • Reimburse at equal rates the uncompensated care costs of all qualifying hospitals ***Increase use of non-state sources of state match*** E.g., Intergovernmental Transfers, certified expenditure, or provider fees or taxes	• Spreading UCC payments among a broader range of providers could give the uninsured greater choice in where they get care. • Additional UCC payments to non-state hospitals would reduce the financial burden of indigent care on those providers. • Use of IGTs or provider taxes or fees could reduce reliance on State General Fund for the state match. Implementation of a December 2000 BA-7 to use certified match from large public hospitals for additional UCC payments to those hospitals is pending.	• Federal Disproportionate Share (DSH) match is capped. UCC spending above the cap is a 100% state liability. Congress recently increased the cap, but only slightly. Additional payments could rapidly hit the new cap. • UCC payments restrict the uninsured to DSH hospitals. Depending on the location of DSH hospitals and patients, distance may limit access to care. • To the extent that UCC payments are made to state and non-state hospitals in the same locale, the payments could contribute to a duplication of services and excess capacity. • UCC payments limit the uninsured to hospital-based care and do not cover outpatient drugs. Increased UCC payments are unlikely to reverse the state's institutional bias in health care (too many hospitals) or improve access to primary care. • LHA estimates hospitals already provide $120 million in uncompensated care for which they receive no payment. Increased UCC payments to these hospitals may not provide for any additional indigent care until payments exceed existing uncompensated care costs.	***Expand Medicaid and LaCHIP eligibility*** E.g.: • Use Section 1931 to cover poor and low-income parents, by increasing the Medicaid work and income eligibility limits • Seek federal approval for a waiver to cover low-income parents with CHIP	• Federal Medicaid match is limited only by the amount a state spends. • Studies show that the uninsured have poorer health status than the insured. Expanding insurance coverage could improve LA's health status rankings. • Studies show that children get better health care when parents also have health insurance. • Low-income parents account for half of the uninsured adult population nationally, and their coverage could substantially reduce LA's percentage of uninsured. • Medicaid patients can choose freely among providers (public or private, near or far). • Medicaid pays for hospital and non-hospital based care, including outpatient drugs and doctor's office and community health clinic visits. • An expansion of the Medicaid Primary Care Case Management Program at the same time as a Medicaid eligibility expansion could directly address the primary care access issue.	• Providers cannot be mandated to see Medicaid patients. For a Medicaid card to guarantee access to health care, Medicaid payment rates must be high enough to attract providers. Current reimbursement rates may have to be increased. In medically underserved areas, even higher rates may not ensure adequate access. • Medicaid eligibility may cause patients to migrate away from LSU hospitals, creating excess capacity and need for forced downsizing to maintain budget neutrality. • Medicaid is an entitlement. Costs cannot be reduced as easily as payments for indigent care in the event of a fiscal problem. • Administrative and outreach costs will increase with a significant expansion of Medicaid eligibility. • Certified expenditure cannot finance a Medicaid expansion. IGTs will not necessarily increase payments contributing providers, as with UCC payments to DSH hospitals.

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